Supreme Court
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No. ____

IN THE SUPREME COURT OF THE UNITED STATES
October Term, 1996

Pan-American Life Insurance Company,
National Insurance Services, Inc.,
Petitioners,

v.

Cypress Fairbanks Medical Center Hospital,
Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED

The Employee Retirement Income Security Act of 1974 ("ERISA"), as amended, preempts state law as it "relates to" an employee benefit plan. 29 U.S.C. § 1144(a) (1994). *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987), held that state law tort causes of action involving claims for benefits under a plan "relate to" the plan and are preempted.

1. Do state law tort causes of action alleging misrepresentation with respect to the availability of benefits provided under an employee welfare benefit plan, brought by a health care provider against the plan, its insurer or its administrator, "relate to" the plan for purposes of ERISA preemption?

RULE 29.6 STATEMENT

Pursuant to Rule 29.6 of the Rules of this Court, petitioners Pan-American Life Insurance Company and National Insurance Services, Inc. state that Pan-American Life Insurance Company is a mutual insurance company owned by its policyholders and National Insurance Services, Inc. is a wholly-owned subsidiary of Pan-American Life Insurance Company.

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IN THE SUPREME COURT OF THE UNITED STATES
October Term, 1996

PAN-AMERICAN LIFE INSURANCE COMPANY,
NATIONAL INSURANCE SERVICES, INC.,
Petitioners,
v.
CYPRESS FAIRBANKS MEDICAL CENTER, INC.,
Respondent.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

Pan-American Life Insurance Company and National Insurance Services, Inc. respectfully petition for a writ of certiorari to review the judgment of the United States Court of Appeals for the Fifth Circuit in this case.

Certiorari should be granted to reaffirm the Court's holding in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987), that state tort claims for benefits under a plan are preempted by ERISA. In the ten years since that holding, the lower courts have fashioned so many exceptions to the rule enunciated in that case that the clarity of the Court's reasoning has been lost, leaving the lower courts in a state of continuing intra- and inter-circuit conflict.

The Court's recent decisions addressing preemption of state regulatory laws threaten to lead to still more analytical confusion as the lower courts ponder what, if any, implications

those cases may have in the area of preemption of state tort law causes of action in benefit claims cases.

OPINIONS BELOW

The opinion of the court of appeals (App., *infra*, 1a-12a) is reported at *Cypress Fairbanks Med. Ctr., Inc. v. Pan-American Life Ins. Co.*, 110 F.3d 280 (5th Cir. 1997). The opinion of the district court (App., *infra*, 13a-16a) is unreported.

JURISDICTION

The court of appeals entered its judgment on April 17, 1997 (App. *infra*, 17a-18a). The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1) (1994).

STATUTORY PROVISION INVOLVED

Section 514(a) of ERISA, 29 U.S.C. § 1144(a) (1994), provides in relevant part that "the provisions of this title and title IV shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan."

STATEMENT OF THE CASE

Petitioner Pan-American Life Insurance Company ("Pan-American"), issued a policy of insurance to fund an employee welfare benefit plan (the "Plan") subject to ERISA. The Plan provided group health coverage to employees of Deborah J. Meyer, M.D., P.A., and their dependents. Mr. Jack Schwartz was enrolled in the plan as an alleged dependent of

Dr. Meyer, who was a full-time employee of her own professional association.

Mr. Schwartz was admitted to Respondent Cypress Fairbanks Medical Center Hospital ("Cypress") for medical services. Cypress contacted National Insurance Services ("NIS"), the Plan's claims administrator, allegedly to determine the existence and extent of coverage for the employee under the Plan. NIS informed Cypress that Mr. Schwartz was enrolled under the Plan as the spouse/dependant of Dr. Meyer. NIS also informed Cypress that in certain circumstances coverage can be rescinded retroactive to the effective date, and that payment was not guaranteed.

After Cypress had provided health care services to Mr. Schwartz, it submitted bills for services to NIS. In the course of processing the bills, NIS learned of several problems with Mr. Schwartz's enrollment under the Plan, including the fact that his application contained material misrepresentations of his medical history and marital status. Mr. Schwartz's coverage was rescinded and NIS denied Cypress's claims.

Cypress sued Pan-American in state court, alleging deceptive trade practices under art. 21.21 of the Tex. Ins. Code,[1] negligence, and negligent misrepresentation. The case was removed to federal court on the basis of federal question jurisdiction and diversity.

The district court determined that the case fundamentally was a claim for benefits from a plan subject to ERISA, and held that Cypress's state law claims were

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[1] Tex. Ins. Code, art. 21.21 (1997) prohibits unfair trade practices in the business of insurance (*id.*, § 3), and includes "misrepresentation," as defined in the statute, as an unfair practice (*id.*, § 4(1)). An aggrieved person may bring a cause of action for violation of the statue and if successful may obtain actual damages, attorneys fees and, for "knowing" violations, treble damages. *Id.*, § 16.

preempted. The court of appeals reversed, holding that the state law claim for misrepresentation was not preempted. The court reasoned that because Mr. Schwartz was not in fact eligible for coverage under the plan, Cypress was an "independent, third party provider" not subject to ERISA preemption. The court of appeals remanded the case to the district court with instructions to remand the case to state court.

REASONS FOR GRANTING THE PETITION

In several recent opinions dealing with state regulatory issues, the Supreme Court has articulated an ERISA preemption doctrine that begins with the presumption that Congress did not intend to displace the historic police powers of the states, such as the regulation of public works, hospital workplace standards, and revenues. [2] In so doing, the Court has taken a definitive step away from the expansive language in *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983), under which state regulatory laws were preempted if they "related to" an employee benefit plan, "in the normal sense of the phrase." *Shaw,* 463 U.S. at 97.

While this "new" analysis pays proper respect to the states' regulatory prerogatives, it raises the specter of wholesale derogation of the Court's decision in *Pilot Life Ins. Co. v.*

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[2] *See New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins.* Co., 514 U.S. 645, 654 (1995) (the "relates to" language was not intended to modify the "starting presumption that Congress does not intend to supplant state law"); *California Div. of Labor Standards Enforcement v. Dillingham Constr., N.A.*, 117 S. Ct. 832 (1997) ("it accurately describes our current jurisprudence to say that...'relates to' is irrelevant") (concurring opinion). *See also De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 138 L. Ed. 2d 21 (1997) (New York Health Facility Assessment's tax on gross receipts on plans not preempted).

Dedeaux, 481 U.S. 41 (1987), and its analytical precursor, *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134 (1985), with respect to state tort causes of action. This is more than a theoretical possibility. Even before the Court's recent decisions, the lower courts had created a confusing mosaic of decisions with respect to tort claims involving benefits, wholly lacking in the analytical clarity that characterized *Russell* and *Pilot Life*. This confusion and resulting conflict exists at both the circuit and the district court levels.

The time has come for the Court to clarify the confusion and make an authoritative statement, in light of its recent preemption decisions, on the scope of ERISA preemption of state tort causes of action with respect to plan benefit claims.

I. The Fifth Circuit's Decision Conflicts with Decisions in the Sixth and Eleventh Circuits, and Unsuccessfully Attempts to Reconcile Conflicting Decisions within the Fifth Circuit over the Scope of Preemption in Cases Involving Claims for Benefits under Employee Welfare Benefit Plans.

In *Massachusetts Mut. v. Russell*, this Court held that ERISA did not authorize an award of extra-contractual or punitive damages arising out of the denial of a claim for benefits under a plan subject to ERISA. The Court was "reluctant to tamper with an enforcement scheme crafted with such evident care as the one in ERISA." *Massachusetts Mut.*, 473 U.S. at 147. Two years later, in *Pilot Life*, the Court elaborated:

> The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely

> undermined if ERISA plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA.

Pilot Life, 481 U.S. at 41.

For the next several years, the lower courts consistently followed *Pilot Life* and held that state law causes of action pled by participants to challenge the denial of benefit claims were preempted by ERISA. *See, e.g., American Fed'n of Unions Local 102 v. Equitable Life Assurance Soc'y.*, 841 F.2d 658 (5th Cir. 1988) (ERISA preempts state law claims against fund administrator for breach of fiduciary duty); *Howard v. Parisian, Inc.*, 807 F.2d 1560 (11th Cir. 1987) (ERISA preempts state law claim for bad faith refusal to pay health benefits). Indeed, the courts routinely extended the reasoning of *Pilot Life* beyond common law causes of action to apply to claims based on state insurance law. *See, e.g., Kanne v. Connecticut Gen. Life Ins. Co.*, 867 F.2d 489 (9th Cir. 1988).

The clarity of this Court's reasoning in *Pilot Life* was not to last, as it was filtered through the facts of the hundreds of cases that were to follow in the next decade. Ironically, it was not the plight of the individual participant or beneficiary that in recent years has impelled courts to create exceptions to the *Pilot Life* doctrine. Some courts unaccountably became determined to provide remedies to health care providers -- usually hospitals -- that the same courts routinely denied to plan participants and beneficiaries. The only way to do that, however, was to invent distinctions that make no legal sense, with the inevitable result of conflicts in the law.

A. The Conflict within the Circuits.

The Fifth Circuit below determined that the hospital's state misrepresentation claim was not preempted because the claim was brought by an "independent, third party provider." *Cypress*, 110 F.3d at 284. The decision places the Fifth Circuit in direct conflict with the Sixth Circuit in *Cromwell v. Equicor-Equitable HCA Corp.*, 944 F.2d 1272 (6th Cir. 1991).

The Sixth Circuit in *Cromwell* faced the identical issue as the Fifth Circuit below: whether a state law claim by a hospital against a plan administrator for allegedly having provided incorrect information on benefits available under the plan is preempted by ERISA. In *Cromwell*, the provider took an assignment of benefits from a plan participant, who later terminated his employment and became ineligible for benefits under the plan. The provider continued to provide treatment after coverage lapsed because the administrator had previously verified coverage. When payment of benefits was denied, the provider sued under various state law theories based on its reliance on the administrator's assurances of coverage.

In conducting the preemption inquiry, the Sixth Circuit recognized that "[i]t is not the label placed on a state law claim that determines whether it is preempted, but whether in essence such a claim is for the recovery of an ERISA plan benefit." *Cromwell*, 944 F.2d at 1276. If so, preemption must follow because the alleged claims are "at the very heart of issues within the scope of ERISA's exclusive regulation." *Id.*

The policy rationale advanced by the hospital could not trump the intent of Congress in ERISA. As the court reasoned, "[i]n the absence of any legal duty between [the administrator, the plan and the provider], ERISA negates [the provider's] attempt to make [the administrator] and the plan an after-the-fact insurer of the [participant's] private debt." *Id.*

Cromwell recognized that a judgment under state law would subject the plan to the laws of individual states concerning the type of damages recoverable in tort, including consequential and punitive damages, which would be paid by the plan, leaving fewer funds available to pay the claims of beneficiaries. *Id.* at 1279 (concurring opinion).

The decision below came to the opposite conclusion on both its policy analysis and preemption result. As a matter of policy, the Fifth Circuit chose to protect the hospital by providing for recovery that would not otherwise be due under the plan, including the potential for extra-contractual damages, at the expense of the plan and legitimate plan beneficiaries. In terms of the result, *Cromwell* looked at the nature of the claim, not its label, to find preemption. *Cypress* looked first at the identity of the claimant, and second at whether the purported beneficiary was ultimately determined to be covered under the plan. If these two factors are in place, labeling the cause of action "misrepresentation" preserves the state cause of action.

More evidence of the conflict between the Circuits can be found in a comparison of the case law in the Eleventh Circuit, which differs from both the Fifth and Sixth Circuits. The Eleventh Circuit, in *Lordmann Enters., Inc. v. Equicor, Inc.*, 32 F.3d 1529 (11th Cir. 1994), *cert. denied*, 116 S. Ct. 335 (1995), employed a different standard from the "proper inquiry" identified by the Fifth Circuit. Based on the Eleventh Circuit's standard, the court determined that a state tort cause of action was not preempted, which would have been preempted in the Fifth Circuit on the court's reasoning below.

In *Cypress*, the Fifth Circuit held that the "proper inquiry" for determining when a claim is subject to preemption is whether the individual is covered under the plan. There was no question in *Lordmann*, however, that the beneficiary was actually covered by the plan. Under the Fifth Circuit's

rationale below, that fact would have led to preemption of the claim. The Eleventh Circuit nevertheless held that a misrepresentation cause of action was not preempted. The state of the law in that Circuit thus appears to be that *any* state law claim for misrepresentation by a health care provider against a plan is preempted. *Id.* at 1534.[3]

The Fourth Circuit has also ruled contrary to the Fifth Circuit in a case with nearly identical facts. In *Healthsouth Rehabilitation Hosp. v. American Nat'l Red Cross*, 101 F.3d 1005 (4th Cir. 1996), *cert. denied*, 138 L. Ed. 2d 194 (1996), the hospital provided services to a patient alleged to have been but not in fact covered under an ERISA health plan. The plan had mistakenly informed the hospital that the patient was covered and later denied the hospital's claim. The hospital sued, including state law causes of action,[4] and the Fourth Circuit held that the hospital's claims were preempted. Thus, although the facts in *Healthsouth* were in material respects the same as those in *Cypress*, the Fourth Circuit reached the opposite conclusion from the Fifth Circuit on preemption.

Other courts have recognized the widespread conflicts within the circuits on this issue. *See Decatur Mem'l Hosp. v. Connecticut Gen. Life Ins. Co.*, 990 F.2d 925, 927 (7th Cir. 1993) (cogent argument on both sides have led to a conflict

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[3] Adding to the confusion, the Eleventh Circuit in *Variety Children's Hosp., Inc. v. Century Med. Health Plan, Inc.*, 57 F.3d 1040 (11th Cir. 1995), distinguished *Lordmann*, suggesting that the "proper inquiry" for determining preemption is not, as the Fifth Circuit held in *Cypress*, whether the beneficiary is covered under the plan, but whether the particular medical treatment is covered. *See* discussion *infra* p. 14, n.10.

[4] The hospital in *Healthsouth* did not allege the specific cause of action of "misrepresentation." That difference alone does not justify disparate treatment under ERISA's preemption provision and *Pilot Life*.

among the circuits); *Coonce v. Aetna Life Ins. Co.*, 777 F. Supp. 759, 768 (W.D. Mo. 1991) (suggests that the Fifth Circuit's reasoning on this issue is misplaced); *Rehabilitation Inst. v. Group Adm'rs, Ltd.*, 844 F. Supp. 1275, 1282 (N.D. Ill. 1994) (as the Seventh Circuit noted in *Decatur Memorial*, cogent arguments have been made in support of both sides of the issue). There is no reason to believe that future cases will bring greater coherence to the question presented in the Petition. Only this Court's authoritative statement will do so.

B. The Intra-Circuit Split.

The division of authority among the Fifth, Sixth and Eleventh Circuits exists as well within several circuits, including the Fifth. Indeed, much of the decision below is an attempt to reconcile two competing Fifth Circuit cases, *Memorial Hosp. Sys. v. Northbrook Life Ins. Co.*, 904 F.2d 236 (5th Cir. 1990) and *Hermann Hosp. v. MEBA Med. & Benefits Plan*, 959 F.2d 569 (5th Cir. 1992). In a major understatement, the court below acknowledged that lower courts in the Fifth Circuit "encountered tension in our cases between Memorial and Hermann Hospital." *Cypress*, 110 F.3d at 283.

That "tension" is the product of the fundamental similarity of the prior cases -- a similarity in everything but result. Both cases involved state tort causes of action by hospitals against benefit plan administrators for negligent misrepresentation of the availability of plan benefits. In both cases the hospitals had taken assignments of the rights of the plan beneficiaries against the plan. But the state tort causes of action were found to be preempted in *Hermann Hospital* and not in *Memorial Hospital*.

1. The Decision in *Memorial Hospital.*

Memorial Hospital took an assignment of benefits from its patient, who claimed to be covered under an employee benefit plan. The plan's insurer allegedly represented to the hospital that the patient was covered under the plan, but later determined that the patient was not in fact eligible for coverage under the plan terms. The hospital sued in state court, asserting various causes of action, including breach of contract, equitable estoppel and negligent misrepresentation, including misrepresentation under article 21.21 of the Texas Insurance Code.[5]

Even though the hospital had a valid assignment of benefits, the court determined that the assignment was "irrelevant" to the hospital's right to recover since it brought the state action in its alleged "independent" status as a hospital. *Memorial Hosp.*, 904 F.2d at 250.

2. The Decision in *Hermann Hospital.*

Hermann Hospital was the second round at the Fifth Circuit involving the same dispute.[6] As reported in the second appeal, the case involved a hospital's treatment of a plan beneficiary after the plan had allegedly confirmed that the

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[5] Because the court concluded that the misrepresentation claim was not preempted under ERISA's general preemption provision, it did not reach the issue whether the claim would have been saved from preemption under ERISA's insurance savings clause, 29 U.S.C. § 1144(b)(2)(A) (ERISA does not "exempt or relieve any person from any law of any State which regulates insurance . . . .") *Memorial Hosp.*, 904 F.2d at 244.

[6] The first decision is reported at 845 F.2d 1286 (5th Cir. 1988).

patient was covered under the plan. The plan later denied coverage, although the basis for the denial is not clear.

Initially, the hospital had sued under § 502 of ERISA, and included state law causes of action for fraud and negligent misrepresentation.[7] The Fifth Circuit held that the hospital did not have standing under ERISA, unless the patient had executed a valid assignment to the hospital of her rights to plan benefits, and remanded for a determination of that fact. The district court held that the hospital did not have a valid assignment.

On the second appeal, the Fifth Circuit reversed, and held that the hospital had standing as an assignee to seek recovery of plan benefits. The court reasoned that assignment of a participant's rights to a health care provider facilitates an employee's receipt of health benefits and supports ERISA's purpose of protecting plan participants and beneficiaries. The court's intent, apparently, was to encourage third party providers to take assignments so that they could sue for plan benefits on behalf of plan participants. *Hermann*, 845 F.2d at 1290 (providers are better situated and financed to pursue an action for benefits owed for their services).

The court ruled that the state law causes of action for fraud and misrepresentation were preempted by ERISA, citing *Russell* and *Pilot Life*. The court rejected the hospital's argument that the court's ruling in *Memorial Hospital* (which was issued between the parties' first and second appearances in the court of appeals) permitted the hospital to maintain a state

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[7] Apparently the hospital in *Hermann* did not sue under Texas Ins. Code, art. 21.21. This fact should be irrelevant to a discussion of the conflict between *Hermann* and *Memorial*, however, as the court in *Memorial* characterized the statutory action as merely a codification of common law misrepresentation, *Memorial Hosp.*, 904 F.2d at 244, and never reached the insurance savings clause issue. *Id.*

law cause of action "independent" of its status as an assignee. The court did so on the ground that the hospital's argument was the same argument rejected in the earlier appeal. As the court stated:

> We clearly held that ERISA preempted Hermann's state law claims irrespective of whether Hermann brought those claims as an enumerated party under ERISA Section 502(a) or in another capacity.

Hermann, 959 F.2d at 578.

The court ruled that this "law of the case" prevailed, despite its intervening decision in *Memorial Hospital* because that case was not controlling authority making a contrary decision on preemption. *Id.* at 579.

> Hermann's state law claims of fraud and negligent misrepresentation are based upon the failure of [the plan] to pay benefits to which Hermann was entitled. . . . Hermann's claims have a nexus with the ERISA plan and its benefit system.

Id. at 578.

3. The Decision Below.

The court below attempted to reconcile these disparate results on the basis that the patient for whose treatment the hospital sought payment was allegedly covered by the plan in *Hermann* ("the hospital was aggrieved over a plan's delay in processing its claim and was seeking recovery of plan benefits

allegedly owed to its assignor")[8] but the patient in *Memorial Hospital*, although originally thought to be covered by the plan, allegedly was not. As the Fifth Circuit noted:

> the proper inquiry is whether the beneficiary under the ERISA plan was covered at all by the terms of the health care policy, because if the beneficiary was not, the provider of health services acts as an independent, third party subject to our holding in Memorial.

Cypress, 110 F.3d at 284.

With the benefit of the court's explanation in *Cypress*, it now appears that the relevant consideration for the court in finding preemption in *Hermann* was that the hospital was "entitled" to benefits under the plan (*id.*) but the plan simply refused to pay.[9] Thus, where no benefits are actually due under the plan, the Fifth Circuit would permit the hospital to recover from the plan not only plan benefits but also extra payments allowed under state law, such as treble damages and attorneys fees under Tex. Ins. Code, art. 21.21, or punitive damages. Where benefits are in fact due but a recalcitrant plan is not paying them, the hospital's remedy is far more limited under ERISA. Permitting greater recovery when benefits are *not* due than when they *are* due cannot be explained by any language in ERISA.

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[8] *Hermann*, 959 F.2d at 249.

[9] Under this standard, a court would not be able to determine whether a cause of action were preempted until the court had resolved the benefits entitlement issue on its merits.

Perhaps more important, the court provided no logical, coherent explanation for why a so-called "independent, third party" is afforded favorable treatment with respect to what are fundamentally claims for benefits under ERISA plans. The party's "independent" claim relates to the plan no less than the same party's "derivative" claim or the plan participant's claim. Whether the facts are those of *Memorial Hospital*, *Hermann*, or *Cypress*, the hospitals did not pick the plan out of a telephone directory. But for the existence of the ERISA plan, the patient's asserted coverage under the plan, the hospital's attempt to obtain the benefits under the plan, and the plan's statement (either directly or through its insurer or administrator) as to the availability and scope of the plan benefits, there would be no claim at all.

The distinction that the Fifth Circuit created below between causes of action that are preempted by ERISA and those that are not "has no basis whatsoever in the language of the statute [§ 514 of ERISA]." *See Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 835 (1988).[10]

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[10] A similar conflict exists in the Eleventh Circuit. In *Variety Children's Hosp., Inc. v. Century Med. Health Plan, Inc.*, 57 F.3d 1040 (11th Cir. 1995), the Eleventh Circuit followed the Fifth Circuit's decision in *Hermann*, holding that state law claims are preempted where the issue is whether a particular service was covered under the plan or was properly denied under an experimental treatment exclusion. *Variety*, 57 F.3d at 1042. The court contrasted this plan interpretation issue, which it found to be preempted, with a "misrepresentation" cause of action, which it held to be unrelated to the plan and thus not preempted. *Id.*, at 1043 (citing *Lordmann Enters., Inc. v. Equicor, Inc.*, 32 F.3d 1529 (11th Cir. 1994), *cert. denied*, 116 S.Ct. 335 (1995)). *Lordmann*, in turn, relied heavily on the Fifth Circuit's decision in *Memorial Hosp. Lordmann*, 32 F.3d at 1534. In *Lordmann/Variety* the Eleventh Circuit has its own *Hermann/Memorial* split.

C. The Policy Choices

The court's decision below has done little to diffuse the tension between its two previous decisions. It offers no practical guidance for determining when the claim of a hospital seeking plan benefits (or the value of alleged plan benefits) is "derivative" of the rights of the plan beneficiary and thus preempted, as in *Hermann*, and when a nearly identical claim, arising in nearly identical circumstances, is "independent" and not preempted, as in *Memorial*.

That is perhaps the inevitable result when a court abandons legal precision in pursuit of a result that promotes the court's notion of preferable social policy. For, despite the variety of formulations the courts have used to justify finding that the claims of hospitals against plans for misrepresentation are not preempted, a closer analysis of those cases suggests that the courts' decisions rest largely, if not exclusively, on the policy grounds set out in *Memorial Hospital*.

In that case, the Fifth Circuit examined the "commercial realities" of a hospital's position, *Memorial Hosp.*, 904 F.2d at 246, and discussed the "allocation of risks between commercial entities that conduct business in a state" (*id.*). But that policy is found nowhere in ERISA. Certainly it is no more compelling than other policies advanced, and rejected, for expanding the remedies available under ERISA.

This Court has already established that ERISA's comprehensive civil enforcement scheme:

> represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans. . . . "The

> six carefully integrated civil enforcement provisions found in § 502(a) [of ERISA, 29 U.S.C. § 1132(a)] of the statute as finally enacted . . . provide strong evidence that Congress did not intend to authorize other remedies that it simply forgot to incorporate expressly."

Pilot Life, 481 U.S. at 54 (quoting *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 146 (1985)).

This case is a perfect example of the mischief that can result from upsetting the balance Congress reached in ERISA. Although the facts of this case remain to be fleshed out in a trial under ERISA, it is clear from the Fifth Circuit's decision that the plan had reason to believe it was entitled to rescind coverage for Mr. Schwartz (*Cypress*, 110 F.3d. at 281, n.1), apparently because of misrepresentations on his application. The decision below would penalize the plan, its insurer and claims administrator for exercising the right to rescind by subjecting them to state tort causes of action, including extra-contractual damages in potentially very large and unpredictable amounts. This result, which is calculated to benefit the hospital, not the patient, at the expense of the plan and its legitimate beneficiaries, strikes exactly the opposite balance that this Court reached in *Pilot Life*. Such a dramatic shift in policy should not escape review by this Court.

II. The Question Presented Is Important Because the Fifth Circuit's Decision Subjects All Employee Benefit Plans to Costly and Disruptive State Law Causes of Action. The Issue Has Been Thoroughly Considered in Various Circuits, So Review of the Question Is Appropriate at This Time.

As the Fifth Circuit observed in *Memorial Hospital*, the scenario giving rise to this appeal "is one that is reenacted each day across the country." *Memorial Hosp.*, 904 F.2d at 246. The question presented in this appeal is potentially at issue every time a plan beneficiary (or purported beneficiary) receives medical treatment from a health care provider that makes coverage inquiries of benefit plans. The number of cases in the district courts and courts of appeal alleging nearly identical fact patterns and seeking resolution of the preemption question testifies to the need for a more enduring resolution than has been forthcoming to date.

Despite the straightforward rule laid down in *Pilot Life*, several of the circuits have fashioned a new enforcement scheme for selected plaintiffs. State tort law causes of action are no longer always preempted, and ERISA's enforcement provisions are no longer always exclusive. For the right plaintiff -- but so far not plan beneficiaries themselves -- suing in the right circuit, who can craft just the right pleading, ERISA preemption is no longer relevant.[11]

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[11] The rationale that would permit hospitals who are assignees of beneficiaries to pursue state tort causes of action not in their capacity as assignees but as "independent, third parties," *Pilot Life* notwithstanding, would appear to permit plan beneficiaries likewise to sue in an "independent" capacity and not as beneficiaries. The dismantling of *Pilot Life* and ERISA's exclusive enforcement scheme would then be complete.

That the Fifth Circuit has strayed from the path laid out in *Pilot Life* is illustrated most vividly by contrasting the opinion below with the court's decision in the first *Hermann Hospital* decision in 1988, the year after *Pilot Life* was decided. In that decision, the Fifth Circuit observed that accepting the hospital's position would allow parties that lacked standing to sue under ERISA to circumvent its enforcement provisions by filing suit in state courts under state law. *Hermann Hospital v. MEBA Med. & Benefits Plan*, 845 F.2d 1286, 1290 (5th Cir. 1988).

> Arguably, they could thus obtain advantages *denied* to parties plaintiff enumerated under [29 U.S.C.] § 1132(a). This is an untenable result.

Id. (emphasis in original).

By its decision below, the Fifth Circuit has done just that. Petitioners and others similarly situated will find themselves facing a variety of state law causes of action brought by health care providers directly related to the plan's administrative functions. These causes of action could require plans to pay plan benefits, in the guise of "damages," to which not even the plan beneficiary would be entitled. Plans would also be subject to extra-contractual damages payable for the benefit of health care providers, which are forbidden to the beneficiary under ERISA. The "untenable result" the Fifth Circuit feared in 1988 is precisely the result the same court has achieved with its decision below.

The split among the Circuits has created confusion and inconsistency in the lower courts. Future cases are certain to continue to make their way through the district courts and courts of appeal, but the decisions rendered to date do not suggest that more cases in more circuits will clarify the issue.

If certiorari is granted, this case can provide needed guidance to the lower courts and halt their slide into large-scale circumvention of this Court's opinion in *Pilot Life*.

CONCLUSION

One of the purposes of both ERISA preemption and the Court's exercise of certiorari jurisdiction is to bring about uniformity of decisions among the federal courts of appeals. For this, and the above reasons, the petition for a writ of certiorari should be granted.

Respectfully submitted,

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Appendix

UNITED STATES COURT OF APPEALS
FIFTH CIRCUIT

CYPRESS FAIRBANKS MEDICAL CENTER, INC.,	§	
	§	
	§	
Plaintiff-Appellant,	§	**CIVIL ACTION**
	§	
	§	**No. 96-20850**
versus	§	
	§	
PAN AMERICAN LIFE INSURANCE COMPANY and NATIONAL INSURANCE SERVICES, INC.	§	
	§	
	§	
	§	
Defendants-Appellees.	§	

[Entered April 17, 1997]
Appeal from the United States District Court
for the Southern District of Texas.

This case requires us to determine the scope of our decision in Memorial Hosp. Sys. v. Northbrook Life Ins. Co., 904 F.2d 236 (5th Cir. 1990), in which we held that a third-party provider's state-law claim for misrepresentation of medical coverage was not preempted by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. §§ 1001-1461. Because we find that the district court erred in concluding that the plaintiff's state-law claim for misrepresentation was preempted, we reverse. In addition,

because this case was removed to federal court on the ground that the plaintiff's claim implicated ERISA--thereby giving rise to federal question jurisdiction--and because we conclude that ERISA is not implicated, we remand this case to the district court with instructions to remand the plaintiff's state-law claim to Texas state court.

BACKGROUND

In December 1993, Deborah J. Meyer established an employee welfare benefit plan which provided group health insurance for Meyer's employees and their dependents. The insurance plan was funded through insurance purchased from the defendant Pan-American Life Insurance Company. National Insurance Services acted as Pan-American's agent. Both parties agree that the health insurance plan is an ERISA plan.

Jack Schwartz, one of Meyer's full-time employees, was admitted to Cypress Hospital and ran up a bill of $178,215.44 in medical services related to a respiratory ailment. Prior to admitting Schwartz, Cypress on two occasions was informed by Pan-American's agent, National Insurance Services, that Schwartz was covered by Meyer's health insurance plan. It is undisputed that Cypress extended health services in reliance on National's representations, that Schwartz was in fact not covered by the health insurance plan, and that National therefore incorrectly informed Cypress about Schwartz's status under the health plan. Cypress eventually submitted a bill for services to National, who refused to pay on the ground that Schwartz's "coverage [was] rescinded as of [the] effective date."[1]

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[1] The meaning of this phrase is not altogether clear. Nor does the (continued...)

Cypress then brought suit against Pan-American and National (defendants) in Texas state court alleging a violation of § 21.21 of Texas's Insurance Code. Specifically, Cypress argued that the defendants negligently misrepresented Schwartz's coverage under the health insurance plan, and as such, were liable for deceptive and unfair trade practices. The case was eventually removed to federal court on the basis of federal question jurisdiction. The defendants then filed a motion to dismiss, or in the alternative, a motion for summary judgment, arguing that Cypress's claim was preempted by ERISA. The district court agreed with the defendants and entered a take-nothing judgment against Cypress. This appeal followed.

DISCUSSION

This case requires us to revisit our holding in Memorial Hosp. Sys. v. Northbrook Life Ins. Co., 904 F.2d 236 (5th Cir. 1990), in which we held that a state-law cause of action for negligent misrepresentation brought pursuant to Texas Insurance Code § 21.21 was not preempted by ERISA. *Id.* at 245-50. Cypress claims Memorial controls this case. The defendants, on the other hand, argue that Memorial is distinguishable because "this Court [in Memorial distinguished between a situation involving an alleged misrepresentation as to the extent of coverage, and one as to the existence of coverage at the time of the misrepresentation." Red

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[1] (...continued)
record reveal the precise reasons for National's denial of coverage. For our purposes, however, Cypress has claimed, and the defendants appear to agree, that National denied coverage because Schwartz was not covered at all under the ERISA plan.

Brief, at 5 (citing Memorial, 904 F.2d at 246[2]). The district court did not rely on or cite our decision in Memorial.[3] Instead, the district court concluded that Cypress's claims are indistinct from a participant's claim that his employer misrepresented the plan benefits. It does not matter whether it was the employee or his hospital that was misled by the benefit plan-related entities. Extensions of coverage however sought are not the plan; the preemption works like a [sic] omnipotent parole evidence rule to block all extension of amounts recoverable from entities whose involvement is related to plan benefits. Blue Brief, Appendix, at 5 (emphasis added). Because we find that the defendants have erroneously concluded that Memorial is inapplicable to this case and that the district court erred in not applying Memorial, we reverse the district court's holding that Cypress's claims are preempted by ERISA.

I. ERISA PREEMPTION AND OUR DECISION IN MEMORIAL

We begin with a brief review of the logic and reasoning of our decision in Memorial because that decision controls our disposition of Cypress's claims in this case. ERISA preempts

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[2] The defendants erroneously cited to page 256 of Memorial. Because our opinion in Memorial does not extend to page 256, we assume that the defendants are directing our attention to page 24 6, which allegedly contains language that supports the defendants' position.

[3] The district court incorporated by reference its preemption opinion "in a parallel case" as the basis for decision in this case. Rec. at 133 (referring to *Hermann Hosp. v. Pan Am. Life Ins. Co.*, 932 F. Supp. 899 (1996)). Our analysis of the district court's reasoning is therefore based on the district court's opinion in Hermann.

"any and all State laws insofar as they now or hereafter relate to an employee benefit plan." 29 U.S.C. § 1144(a) (emphasis added). In Memorial, we set out to define the meaning of "relate to" in cases involving independent, third-party providers of medical services, who assert state-law causes of action for misrepresentation against insurance companies
that have misrepresented the existence of health coverage to the detriment of the third-party provider.

Memorial Hospital was incorrectly informed by Northbrook Insurance Company that an employee of Noffs, Incorporated was covered under Noffs's health insurance plan. The benefit plan came within ERISA's scope. After tendering the employee's hospital bill to Northbrook, Memorial was informed that the employee in fact was not covered under Noffs's plan. Memorial sued, alleging, among other things, negligent misrepresentation in violation of § 21.21 of Texas's Insurance Code. The district court held that Memorial's state-law cause of action for misrepresentation was preempted by ERISA.

We reversed. In reaching our conclusion that Memorial's state-law claim for negligent misrepresentation was not preempted, we initially made a distinction between hospitals who assert a derivative claim for benefits (i.e., the hospital stands in the shoes of the beneficiary of the plan) and independent, third-party claims brought by health care providers such as Memorial. 904 F.2d at 243-44. To determine on which side of the line Memorial fell, we looked to our prior cases in which we found ERISA preemption had two unifying characteristics: (1) the state law claims address areas of exclusive federal concern, such as the right to receive benefits under the terms of an ERISA plan; and (2) the claims directly affect the relationship among the traditional ERISA entities--the employer, the plan and its fiduciaries, and the participants and beneficiaries. 904 F.2d at 245 (footnotes

omitted).[4] We concluded that Memorial fit into neither category and was therefore asserting its state-law claim for misrepresentation as an independent, third-party provider of medical services.

We asserted three justifications for our conclusion. First, we recognized the "commercial realities" facing third-party providers of health care services, noting that in situations in which it is not clear whether a patient is covered by a health insurance plan, "the provider wants to know if payment reasonably can be expected. Thus, one of the first steps in accepting a patient for treatment is to determine a financial source for the cost of care to be provided." 904 F.2d at 246.

Second, when an insurance company erroneously informs a health care provider such as Memorial that a patient is covered by health insurance, state law, which "allocates ... risks between commercial entities that conduct business in a state," normally provides a remedy. Id. at 246-47. This is so, we reasoned, because "[a] provider's state law action under these circumstances would not arise due to the patient's coverage under an ERISA plan, but precisely because there is no ERISA plan coverage." Id. at 246.

Third, depriving an independent third-party provider of a state-law cause of action in no way furthers, but rather defeats, Congress's purpose behind enacting ERISA. We recognized in Memorial that third-party providers would be less likely to accept the risk of nonpayment, and as a result, may require patients to make up-front payments or subject those patients to other unnecessary inconveniences before treatment is offered.

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[4] We have since followed this two-part inquiry in ERISA cases. See *Hook v. Morrison Milling Co.*, 38 F.3d 776, 781 (5th Cir. 1994); *Weaver v. Employers Underwriters, Inc.*, 13 F.3d 172, 176 (5th Cir.), *cert. denied*, 511 U.S. 1129, 114 S. Ct. 2137, 128 L. Ed. 2d 866 (1994).

Id. at 247. Nor, we reasoned, could Congress have wanted to "shield welfare plan beneficiaries from the consequences of their acts toward non-ERISA health care providers when a cause of action ... would not relate to the terms or conditions of a welfare plan, nor affect--or affect only tangentially--the ongoing administration of the plan." Id. at 250.

In short, in Memorial, we staked out the policy arguments which support the conclusion that ERISA does not preempt a third-party provider's state-law claims if that third party's claim is premised on a finding that the beneficiary is not covered at all by an existing ERISA plan. As such, we defined what it meant for a third party's state-law claims to "relate to" an ERISA plan, premising our conclusion on the commercial realities faced by third-party providers, basic notions of federalism, and Congress's intent behind enacting ERISA.

II. POST-MEMORIAL TENSION IN OUR CASE LAW

After we decided Memorial, some lower courts within our Circuit encountered a tension in our cases between Memorial and Hermann Hosp. v. MEBA Medical & Benefits Plan, 845 F.2d 1286 (5th Cir. 1988) (Hermann I) and Hermann Hosp. v. MEBA Medical & Benefits Plan, 959 F.2d 569 (5th Cir. 1992) (Hermann II).[5] In Hermann I and Hermann II, we held that a third-party provider's state-law claims were preempted by ERISA. It therefore became unclear whether our holding in Memorial applied to all third-party providers of medical

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[5] See Metroplex Infusion Care v. Lone Star Container, 855 F. Supp. 897, 900-01 (N.D. Tex. 1994); Oaks Psychiatric Hosp. v. American Heritage Life Ins. Co., 814 F. Supp. 553, 555 (W.D. Tex. 1993); Forest Springs Hosp. v. Illinois New Car & Truck Dealers Ass'n Employees Ins. Trust, 812 F. Supp. 729, 732-33 (S.D. Tex. 1993); Brown Schs., Inc. v. Florida Power Corp., 806 F. Supp. 146, 150 (W.D. Tex. 1992).

services (contra to Hermann I and Hermann II) or whether Memorial invited lower courts to conduct a fact-sensitive inquiry into whether the third-party provider, under the unique circumstances of each case, could properly be characterized as an independent, third-party provider or as an assignee asserting a derivative claim for ERISA benefits. Accordingly, we take this opportunity to clarify the scope of Memorial in light of Hermann I and Hermann II and conclude that the cases are consistent with another.

In Hermann I, 845 F.2d 1286, Hermann Hospital provided a patient medical services after Hermann was informed by MEBA (the insurance company) that the patient was covered by a health plan governed by ERISA. The patient, who had died, assigned her rights to the benefits of the health plan to Hermann. MEBA neither declined nor tendered payment, but told Hermann that the claim was being "investigated." Hermann then filed suit, alleging state-law causes of action for breach of fiduciary duty, negligence, equitable estoppel, breach of contract, and fraud. Hermann did not assert violations of Texas's Insurance Code. We held that Hermann's claims were preempted by ERISA. Id. at 1290. An important element of our holding in Hermann I was our reading of the Supreme Court's decisions in Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 107 S. Ct. 1549, 95 L. Ed. 2d 39 (1987) and Metropolitan Life Ins. Co. v. Taylor, 481 U.S. 58, 107 S. Ct. 1542, 95 L. Ed. 2d 55 (1987). These cases, we reasoned, stood for the proposition that where a claim relates to an employee benefit plan governed by ERISA and are "based upon state law of general application and not a law regulating insurance, " that state-law cause of action is preempted by ERISA. Hermann I, 845 F.2d at 1290.

In Hermann II, 959 F.2d 569, we did nothing more than hold that our preemption determination in Hermann I was the law of

the case in Hermann II. Id. at 578. Accordingly, Hermann II adds nothing to our understanding of ERISA preemption.

However, we did clarify the meaning of Hermann I in Memorial. In footnote 20, we distinguished Hermann I on the ground that "the hospital was aggrieved over a plan's delay in processing its claim and was seeking recovery of plan benefits allegedly owed to its assignor." 904 F.2d at 249 n.20. We further suggested that Hermann I did not control the situation faced by Memorial Hospital because the claims in Hermann I were "dependent on, and derived from, the rights of the plan beneficiaries to recover benefits under the terms of the plan." Id. Stated differently, Hermann Hospital was not an independent, third-party provider of medical services, but rather more akin to a first-party beneficiary whose causes of action are normally preempted by ERISA.[6] Because Hermann I was decided before Memorial, Hermann II did not discuss ERISA preemption, and because we have never questioned the holding or analytical underpinnings of Memorial, our understanding of Hermann I as expressed in Memorial is the law of this Circuit.

As such, the difference between Hermann I and Memorial has nothing to do with the bare existence of an ERISA plan. Rather, the proper inquiry is whether the beneficiary under the ERISA plan was covered at all by the terms of the health care policy, because if the beneficiary was not, the provider of health services acts as an independent, third party subject to our

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[6] See, e.g., Hogan v. Kraft Foods, 969 F.2d 142, 144-45 (5th Cir. 1992); Ramirez v. Inter-Continental Hotels, 890 F.2d 760, 763-64 (5th Cir. 1989).

holding in Memorial. This is no doubt what our district courts have understood Memorial to mean.[7]

III. APPLICATION OF MEMORIAL TO CYPRESS'S STATE-LAW CAUSE OF ACTION FOR MISREPRESENTATION

Pan-American and National argue that Memorial does not control this case because in its pleadings, Cypress admitted that it was inquiring about the extent rather than the existence of coverage for Schwartz. In addition, Pan-American and National argue that because an ERISA plan was in place and Schwartz

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[7] See Jefferson Parish Hosp. Dist. No. 2 v. Principal Health Care of La., Inc., 934 F. Supp. 206, 208 (E.D. La. 1996) ("The patient's assignment of right in this action is irrelevant to the hospital's right to recover from the plan in its independent status as a hospital."); Cornett v. Aetna Life Ins. Co., 933 F. Supp. 641, 644 (S.D. Tex. 1995) ("A careful distinction was drawn [in Memorial] between plan participants, on the one hand, and independent, third-party health providers, on the other...."); Metroplex Infusion Care, 855 F. Supp. at 901 ("The apparent contradiction between the Hermann cases and Memorial may be resolved in light of their underlying factual differences: whereas there was no ERISA coverage in Memorial, so that the hospital would have had no recourse under either ERISA or state law had its state law claims been preempted, in Hermann ERISA coverage did not exist but had allegedly been improperly denied."); Forest Springs, 812 F. Supp. at 732 ("The facts in Hermann differed from that of Memorial ... because the dispute in Hermann centered around an alleged misrepresentation as to the extent of coverage, not a situation where, like here and in Memorial ..., the defendant contends there is no coverage at all."); Brown Schools, 806 F. Supp. at 150 ("The apparent reason for the discrepancy between the cases is that in Memorial there was no ERISA coverage and therefore the hospital would have "no recourse under either ERISA or state law' if the hospital's state law claims were preempted ..., whereas in the Hermann cases, ERISA coverage existed but was allegedly improperly denied.").

was enrolled in the plan, Cypress's state-law claim should be preempted by ERISA.

The defendants' position is unavailing because Schwartz, although enrolled in the plan, was not covered by the health care plan insured by Pan-American and National. It is undisputed that National refused to pay Cypress because "coverage [was] rescinded as of [the] effective date." Admittedly, because no discovery took place in this case, the record is unclear as to the meaning of this phrase. Nor does the record reveal the precise reasons behind National's refusal to pay for Schwartz's services. Nonetheless, Cypress has asserted, and the defendants do not dispute, that coverage was denied because Schwartz was not covered by the health plan. Indeed, neither National, Pan-American, nor the record suggest that "coverage rescinded" means anything else than Schwartz was not covered by the plan at the time of his hospitalization. As such, Cypress's cause of action does not relate to ERISA, but rather arises under state law. Memorial is therefore triggered. Cypress's state-law claim under § 21.21 for misrepresentation is not preempted by ERISA.

Finally, the district court's reasoning is of no help to the defendants.[8] As we have pointed out, the district court concluded that for ERISA purposes, third-party providers such as Cypress are on no better footing than first-party beneficiaries. We rejected that premise in Memorial, where we reasoned as follows:

We have held under different circumstances that ERISA preemption may occur even though ERISA itself could not offer an aggrieved employee a remedy for alleged

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[8] We note that the defendants do not rely on or attempt to justify the district court's reasoning in this case.

misrepresentations. That principle should not be extended, however, to encompass third-party providers, particularly when to do so would run counter to one of Congress's overriding purposes in enacting ERISA. 904 F.2d at 248 (emphasis added) (footnote omitted). The district court's reasoning to the contrary is foreclosed by Memorial.

CONCLUSION

Because the district court erroneously determined that Cypress's state-law cause of action for violating § 21.21 of Texas's Insurance Code was preempted by ERISA, we REVERSE the district court's decision. In addition, the district court's jurisdiction to hear this case was based on the federal question presented by ERISA preemption, and because we hold that ERISA is not implicated, we REMAND this case to the district court with directions to remand Cypress's § 21.21 claim to Texas state court.

REVERSED AND REMANDED.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF TEXAS

CYPRESS FAIRBANKS MEDICAL CENTER HOSPITAL,	§	
	§	
Plaintiff,	§	CIVIL ACTION
	§	H-95-586
versus	§	
PAN AMERICAN LIFE INSURANCE COMPANY and NATIONAL INSURANCE SERVICES,	§	
Defendants.	§	

Opinion on Preemption
[Entered August 1, 1996]

1. *Facts.*

On February 3, 1994, Jack Schwartz was admitted to Cypress Fairbanks Medical Center for injuries from an automobile accident. Schwartz was a member of a Group Health Insurance Plan through Pan-American Life and administered by its agent, National Insurance Services. The plan was furnished to Schwartz through his employer, Deborah J. Meyer, M.D., P.A. On February 1, Cypress Fairbanks contacted National Insurance Services to determine Schwartz's insurance coverage by Pan American. On both February 1 and 3, benefits were verified by National Insurance Services.

Claiming it relied on these representations, Cypress Fairbanks furnished $178,215.44 in medical treatment to Schwartz. Four months later, National Insurance Services denied coverage, refusing to pay the claim.

2. *Claims.*

Cypress Fairbanks sued Pan-American and National to recover for the unpaid medical services, alleging deceptive trade practices, negligence, and negligent misrepresentation in the handling of the hospital's claims. Pan-American seeks to dismiss Cypress's claims on the grounds that they are preempted by the federal law on benefit plans. Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 - 1461.

3. *Decision.*

Based on this court's reasoning in a parallel case, Cypress Fairbanks Medical Center Hospital will take nothing from Pan American Life Insurance Company and National Insurance Services. See *Hermann Hosp. v. Pan American Life Ins. Co.*, Civil Action 93-1544.

Signed July 29, 1996, at Houston, Texas.

Lynn N. Hughes
United States District Judge

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF TEXAS

CYPRESS FAIRBANKS MEDICAL CENTER HOSPITAL,	§	
	§	
Plaintiff,	§	CIVIL ACTION
	§	H-95-586
versus	§	
PAN AMERICAN LIFE INSURANCE COMPANY and NATIONAL INSURANCE SERVICES,	§	
Defendants.	§	

Final Judgment
[Entered August 1, 1996]

Cypress Fairbanks Medical Center Hospital takes nothing from Pan American Life Insurance Company and National Insurance services.

Signed July 29, 1996, at Houston, Texas.

Lynn N. Hughes
United States District Judge

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF TEXAS

CYPRESS FAIRBANKS MEDICAL CENTER, INC.,	§	
Plaintiff,	§	CIVIL ACTION
	§	H-95-586
versus	§	
PAN-AMERICAN LIFE INSURANCE CO., *et al.*,	§	
Defendants.	§	

Order to Remand

Although there is more to common-law reasoning and *stare decisis* than institutionalization of errors and recognizing that no writ runs to the rational faculties, this case is remanded to the 34th District Court of Harris County, Texas, as the mandate requires.

Signed May 14, 1997, at Houston, Texas.

Lynn N. Hughes
United States District Judge

UNITED STATES COURT OF APPEALS
FIFTH CIRCUIT

No. 96-20850
Summary Calendar

D.C. Docket No. H-95-CV-586

CYPRESS FAIRBANKS MEDICAL CENTER INC
Plaintiff-Appellant

v.

PAN AMERICAN LIFE INSURANCE COMPANY;
NATIONAL INSURANCE SERVICES, INC.
Defendants-Appellees.

Appeal from the United States District Court
for the Southern District of Texas, Houston.

Before DAVIS, EMILIO M. GARZA, and STEWART, Circuit Judges.

JUDGMENT
[Filed April 17, 1997]

This cause came on to be heard on the record on appeal and was taken under submission on the briefs on file.

ON CONSIDERATION WHEREOF, it is now here ordered and adjudged by this Court that the judgment of the District Court in this cause is reversed, and the cause is remanded to the District Court for further proceedings in accordance with the opinion of this Court.

IT IS FURTHER ORDERED that defendants-appellees pay to plaintiff-appellant the costs on appeal to be taxed by the Clerk of this Court.

ISSUED AS MANDATE: MAY 09 1997

OP-S-J-1